CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 427 • Columbia, South Carolina 29202
Phone (800) 433-3036 Fax (866) 849-2970

Aflac

HOSPITAL INDEMNITY CLAIM FORM

Failure to complete all sections may result in a delay in processing this claim.
To prevent delays, please provide documentation from your healthcare provider to support this claim.
Please review your policy for specific benefits covered under your plan.

✓ **Benefits are payable to you unless we receive written authorization from your provider to assign benefits to them or from you to pay your benefits elsewhere. This is called an assignment. If you wish to assign your benefits, please send a signed written request.**

✓ **If this claim is for an individual covered by Medicaid or a state variation of Medicaid, most non-disability benefits are automatically assigned according to state regulations. This means we must pay the benefits to Medicaid or to the medical provider to reduce the charges billed to Medicaid.**

Authorization

Several states require that the following statement appear on claim forms: **Any person who knowingly attempts to defraud any insurance company, files a statement of claim containing any materially false, incomplete or misleading information, is guilty of a crime.**

I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledg and belief. I have read the fraud notice included in this form.

Policyholder's signature: Jay Gray Date: 5-16-16

Patient's Signature: Jay Gray Date: 5-16-16

POLICYHOLDER'S / PATIENT INFORMATION

Employer's Name	Policyholder's Email Address			
Genesis Healthcare	J.GRAY1010@Comcast.net			
Policyholder's Name	**Policy No**	**Social Security No**	**Date of Birth**	**Gender**
CJAY GRAY	21033-2924	164-68-5399	7-17-84	female
Policyholder's Address	**City**	**State**	**Zip Code**	**Policyholder's Telephone No. (with area code)**
PO BOX 122	Atglen	PA	19310	484-366-9881
Patient's Name (Person who is sick or injured)	**Patient's Date of Birth**	**Patient's Gender**	**Relationship to Policyholder**	
CJAY GRAY	7-17-84	Female	me	

By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys and other materials that CAIC is, or may be, legally required to deliver to you).

Please complete the remaining sections for all claims:

Please provide the name, address and phone number of the patient's primary treating physician.

Name: Gateway Phone Number: 610-466-7634

Address: 217 Reeceville Rd City/State/Zip: Coatesville PA, 19320

- Was the patient confined to the hospital as a result of this condition? ____ No ✓ Yes

(If confined, please submit copy of patient's admission and discharge papers or a copy of a UB-04 billing invoice from the hospital)

Hospital (Facility) name: Chestercounty Phone Number: 610-431-5000

Admission date: 3-13-16 Discharge Date: 3-17-16

If yes, please complete the below:

Employer Facility Benefit Provision

(for insureds who have employer facility benefits)

Name of Hospital (Facility) name where patient was admitted, confinement or received treatment: Chestercounty Phone Number: 610-431-5000

Address: 701 E marshall st City/State/ZIP: Westchester PA, 19380

Is this facility also your place of employment? ✓ No ____ Yes

If no, does this facility partner with your employer's healthcare system? ✓ No ____ Yes

- Was the patient confined to the intensive care unit as a result of this condition? ✓ No ____ Yes

(If yes, please submit copy of a UB-04 billing invoice from the hospital facility to identify the days spent in the intensive care unit)

- Was the patient confined to a rehabilitation unit as a result of this condition? ✓ No ____ Yes

(If yes, please submit copy of patient's admission and discharge papers or a copy of a UB-04 billing invoice from the hospital)

- Was the patient treated in an emergency room as a result of this condition? ✓ No ____ Yes

(If yes, please submit emergency room admission and discharge papers)

- Was surgery performed as a result of the medical condition? ✓ No ____ Yes

(If yes, please submit a copy of the operative report.)

**For outpatient prescription drug benefits, please submit pharmacy receipts showing the name of the prescription, the physicia name prescribing it and the date prescribed.

Please sign the attached HIPAA Form and return it with the completed claim form.

*****If filing a claim within the first policy year for benefits, medical records may be requested*****

Is medical treatment due to an injury? No ✓ Yes _____

- If yes, please complete the following questions related to the injury:
- Date of the injury: _____
- Describe how the injury occurred:

_____
_____
_____
_____
_____

- Location of the injury: _____ On the job ✓ Off the job
- Was the patient injured in a motor vehicle accident? ✓ No _____ Yes - (If yes, please submit the Police Repo

Is treatment due to a sickness? _____ No ✓ Yes

If Yes, please complete the following questions related to the sickness

- What is your sickness diagnosis: VIRUS
- Symptoms first occurred on what date: 3-10-16
- First date of treatment for this condition: 3-13-16
- If diagnosed with Cancer, on what date was the initial diagnosis? _____
  (Please submit pathology report with your claim submission if diagnosed with Cancer)
- Was the patient treated by any other physicians for this sickness or a related condition?
  - ✓ No _____ Yes
  - If yes, please provide the physician's name(s), address(es) and phone number(s) inside the box below.

Treatment Date	Physician Name	Address	City,State,Zip	Phone Number

Pregnancy claims:

- Date of delivery: _____
- Type of Delivery: _____ Vaginal _____ Cesarean
- If not delivered, expected delivery date: _____
- What was the date of your last menstrual period? _____

- Please list any complications due to your pregnancy:

_____
_____
_____
_____

CONTINENTAL AMERICAN INSURANCE COMPANY
Post Office Box 427* Columbia, South Carolina 29202
Phone (800) 433-3036 Fax (866) 849-2970

Aflac

AUTHORIZATION TO OBTAIN INFORMATION

MAIL TO: Continental American Insurance Company
P.O. Box 427
Columbia, South Carolina 29202

CALL: 1.800.433.3036 (toll-free)
CLAIM FAX: 1.866.849.2970

Primary Certificateholder's Name:	SSN(optional):	Date of Birth:
CJAY GRAY	164-68-5399	7-17-84
Certificate Number(s):	21033-29245	
Address: P.O. Box 122 Ardglen PA. 19310		7-17-84
Name of Individual Subject to Disclosure (If not the primary Certificateholder):		**Date of Birth:**

Relationship to Primary Certificateholder:
☑ Self ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Stepchild ☐ Grandchild

I. Authorization:
For the purpose of evaluating my *eligibility for insurance and for benefits* under an existing certificate, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for coverage and/or claim form, I hereby authorize the disclosure of the following information(defined below) about me and, if applicable, my dependents, from the sources listed below to Continental American Insurance Company (CAIC), or any person or entity acting on its part, to include American Family Life Assurance Company of Columbus and American Family Life Assurance Company of New York (collectively, "Aflac).

II. Disclosure of Health Information:
Health information may be disclosed by any health care provider, health plan (including CAIC or Aflac, with respect to other CAIC or Aflac coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. CAIC will not disclose the information unless permitted or required by those laws.

III. Rights and Expiration:
I understand that I may revoke this authorization at any time, except to the extent that CAIC or Aflac has taken action in reliance on this authorization. If I revoke this authorization, CAIC may not be able to evaluate my application for coverage and/or claim. To revoke this authorization, I must provide a written and signed revocation to CAIC at the address or fax number above. Unless otherwise revoked, this authorization shall remain in effect for two (2) years from the date signed or upon my death, whichever occurs first. I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.

IV. Notice:
I understand that CAIC is not conditioning payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

- **If records are on an adult dependent, (e.g. spouse, child over 18), the dependent must sign this form**
- **If records are on a minor child the natural parent or legal guardian must sign on their behalf.**

Cjay Gray — 5-15-16
Signature of Individual Subject to Disclosure — Date Signed

CJAY GRAY — Cjay Gray — me — 5-15-16
Legal Representative's Printed Name — Legal Representative's Signature — Legal Relationship — Date Signed

If signed by a legal representative (e.g. Legal Guardian, Estate Administrator, Power of Attorney)

Aflac

Electronic Funds Transaction Authorization

Send to: **Continental American Insurance Company**
Post Office Box 427
Columbia, South Carolina 29202

Phone: (800) 433-3036 Fax (866) 849-2970
Email: groupclaimfiling@aflac.com

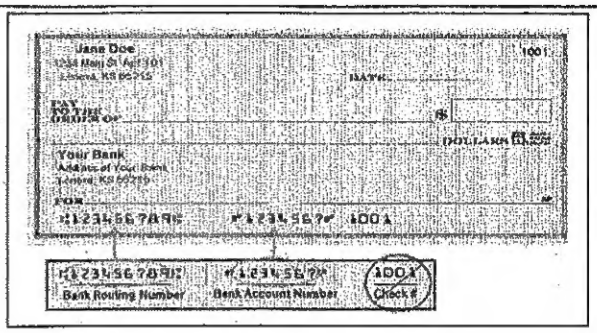
I would like to:

☑ Start ☐ Stop ☐ Change direct deposit of my claim payment(s).

Account Type:

☑ Checking ☐ Savings

****** Please provide a blank voided check or direct deposit form from your financial institution. Incomplete or inaccurate information will not be processed.**



9-Digit Routing Number: 231380104	Account Number: 5634046
Name of Financial Institution: Citadel	
Address: 520 Eagleview Blvd	City: Exton
State: PA / Zip: 19341	Phone: 1800-666-0191

Authorization Agreement for Direct Deposit

I authorize Continental American Insurance Company (CAIC) to initiate credit entries, and, if errors occur, I authorize the correction of entries to my account as indicated. This authorization remains effective and in full force until CAIC receives written notification from me of its termination in such time and in such manner to afford CAIC a reasonable opportunity to act on it. Please notify CAIC immediately if your financial institution information has changed by sending notification to the address indicated above. Should you have any questions, please contact us at 1-800-433-3036.

Policy/Certificate Holder's Name (*Print*): CJAY GRAY	
Address: P.O. BOX 122	City/State/Zip: Atglen PA. 19310
Phone #: 484-366-9881	E-mail Address: J.GRAY1010@comcast.net
Employer Name or Group #: Genesis Healthcare	Certificate #: 2272622

By providing your e-mail address above, you consent to the use of electronic transactions in connection with your CAIC policies, contracts, and/or accounts to the extent available and permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that CAIC is, or may be, legally required to deliver to you)

Cj Gray
Policy/Certificate Holder Signature ***(Required)***

5-16-16
Date

Note: Forms received without signature will **not** be processed.

1	2	3a PAT. CNTL #	4 TYPE OF BILL
The Chester County Hospit 701 E Marshall Street West Chester PA 193804412 6104315000 US	The Chester County Hospit PO Box 2701 West Chester PA 19380	S99401800101 b. MED. REC. # 580033	0111

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7
23-0469150	031316	031716	

8 PATIENT NAME	9 PATIENT ADDRESS
a	a 323 Ridge Ave
b GRAY, CJAY A	b Atglen c PA d 19310 e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
07171984	F	031316	23	1	1	16	01													

	31 CODE	31 OCCURRENCE DATE	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE SPAN FROM	THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
a	11	031116	A1	071784											
b															

38 Blue Cross IBC Trad/Independ
1901 Market Street
Philadelphia, PA 19103

Parallel Claim

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	01	218500	A3	1280069		
b						
c						
d						

	42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0120	ROOM-BOARD/SEMI	2185.00		4	874000		1
2	0250	N400206885416ML1633.25			216	359720		2
3	0260	IV THERAPY			3	67800		3
4	0300	LABORATORY			8	39800		4
5	0301	LAB/CHEMISTRY			22	217400		5
6	0305	LAB/HEMATOLOGY			6	52600		6
7	0306	LAB/BACT-MICRO			20	315000		7
8	0307	LAB/UROLOGY			1	3900		8
9	0309	LAB/OTHER			3	23100		9
10	0324	DX X-RAY/CHEST			1	18200		10
11	0351	CT SCAN/HEAD			1	140300		11
12	0352	CT SCAN/BODY			1	183100		12
13	0361	OR/MINOR			1	81700		13
14	0450	EMERG ROOM			1	141800		14
15	0730	EKG/ECG			1	22200		15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23	0001	PAGE 1 OF 1		CREATION DATE 032216	TOTALS →	2540620		23

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A Blue Cross IBC Trad/Ind	99999	Y	Y	000	2540620	1356333579	57
B							OTHER
C							PRV ID

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A	GRAY CJAY A	18	GEA121273955001		10106203
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A	13140686		Brandywine Hall
B			
C			

66 DX												68
	A4189 Y	I959 N	A084 Y	R51 Y	R938 Y	Z90710 1	Z87891 1					
	0											

69 ADMIT DX	70 PATIENT REASON DX				71 PPS CODE	72 ECI				73
R509					0872					

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	75
009U3ZX	031316					
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI 1720373962	QUAL	
LAST Solondz		FIRST Marcie	
77 OPERATING	NPI 1295741429	QUAL	
LAST Kelton		FIRST Franklin	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS

81 CC		
a	B3	282N00000X
b		
c		
d		

Citadel

ACH/Payroll Authorization Form

Please print, complete and submit to your company's Payroll or Human Resources Department.

Member Name: CJAY ANN GRAY Account #: 10700000563406

Transit/ABA Number: 2313-8010-4 Company Name: _____

Total amount deducted:	☐ Net Check ☐ Partial Deduction $ _____
Primary account for deposit:	☐ Savings ☐ Checking

I hereby authorize the above named company to begin Automated Clearing House (ACH/payroll deduction) credit to the above account(s) in the amount(s) listed. In the event the payroll is not forwarded in a timely manner by my company, any loan payments due will be made at the credit union.

Member Signature:

Signature Jay Gray Date 05/23/2016